ADMINISTRATIVE POLICY AND PROCEDURE		
Policy #:	**162**	
Subject:	**Placements – Long Term Care, Skilled, Sub-Acute, Acute, Rehabilitation, and MCO Disenrollments to Long Term Care**	
Section:	**Care Management**	
Initial Effective Date:	**09/01/2000**	
Revision Effective Date(s):	**07/18, 07/19, 07/20**	
Historical Revision Date(s):	**10/01, 09/02, 04/03, 10/03, 09/04, 10/05, 12/06, 10/07, 09/08, 11/09, 09/10, 09/11, 10/12, 11/13, 07/14, 10/14, 10/15, 10/16, 01/17, 07/17**	
Review Effective Date(s):		
Historical Review Date(s):		
Responsible Parties:	**Theresa Bittle, Blaine Willis**	
Responsible Department(s):	**Case Management**	
Regulatory References:	**COMAR: 10.67.06.12, MDH Hospital Transmittal No. 245, MDH Nursing Home Transmittal No. 213**	
Approved:	**Theresa Bittle, RN** **AVP, Clinical Operations**	**Patryce A. Toye, MD** **Chief Medical Officer**

Purpose: **To define a process for arranging for inpatient alternatives to acute care.**

Scope: **MedStar Family Choice**

Policy: **Care Management staff will collaborate with the MedStar Family Choice (MFC) Post-acute Case Manager(s) to assure appropriate placements to post acute care facilities and process for coordinating disenrollments from Managed Care Organization (MCO) to long term care.**

Procedure:

A. Inpatients:
1. The MFC Post-Acute Case Manager (CM) reviews cases upon admission for any anticipated placement needs. Hospital CMs are requested to discuss length of stay, and anticipated care needs with the member and family.

2. The CM uses InterQual, and MDH Nursing Home Transmittal No. 213 along with information from the hospital (including discharge screens) to assure medical necessity

and the appropriate level of care. If a member will require care in another facility beyond discharge, the Hospital CM is educated as to in-network facilities, which have the capability of providing the needed care. The name and number of the MFC Post-Acute CM is provided.

3. Out-of-network facilities may be considered in the following circumstances:
    a. The patient requires care that is not available at an in-network facility.

4. The Hospital CM and/or the facility liaison will call the MFC Post-Acute CM to arrange admission to the facility. Demographic and clinical information are provided. The minimum necessary information will be provided to the MFC Post-Acute CM.

5. If the member meets Post-Acute InterQual Criteria, the MFC Post-Acute CM will negotiate a level of care, assign an initial length of stay, and create the authorization in the clinical software system. Authorizations for specialized services such as transportation, intravenous antibiotics, and specialty beds will also be provided.

6. When the Subacute/ Skilled Nursing Facility (SAC/SNF) criteria in InterQual is exhausted after the first 28 days of a member's stay and the member remains at the SAC/SNF facility; the MFC nurse reviewer can approve a member's continued stay when the following conditions are met up to day 90 of the stay.
    a. Member is still receiving one or more disciplines of PT, OT or ST and progressing toward goals.
    b. Member is receiving IV antibiotic therapy and their condition or social situation does not allow them to receive this service safely in a home setting.
    c. Member is receiving wound care and the member cannot be taught, is not physically capable to complete, does not have adequate support at home, or the wound care cannot be provided through home care due to the frequency or complexity of care.
    d. Member needs additional teaching on their disease state and/or medication management due to cognitive issues.
    e. Medical management that is needed cannot be safely completed in a home setting due to the frequency or complexity of care.
    f. Member can no longer care for self and there are no family members or willing family members to care for member and the plan is to reside in the SAC/SNF as a long-term care resident.
    g. Member is determined to be: A member above custodial care not requiring skilled nursing services or rehabilitation services may be determined medically eligible for a SAC/SNF if they require, on a regular basis, health-related services above the level of room and board. These services are described as follows:

i. Care of an individual who requires hands-on assistance to adequately and safely perform two or more activities of daily living (ADLs)[1] as a result of a current medical condition or disability; or
ii. Supervision of an individual's performance of two or more ADLs for an individual with cognitive deficits, as indicated by a score of 15 or less on the Folstein Mini-Mental Status Evaluation, and who is in need ofassistance with at least three instrumental activities of daily living (IADLs)[2]; or
iii. Supervision of an individual's performance of two or more ADLs combined with the need for supervision/redirection for an individual exhibiting at least two of the following behavior problems: wandering several times a day, hallucinations/delusions at least weekly, aggressive/abusive behavior several times a week, disruptive/socially inappropriate behavior several times a week, and/or self-injurious behavior several times a month.

Once these conditions are no longer met, the expectation is that the member will be discharged to the community. In the event that the SAC/SNF requests authorization for continued stay, the days will be pended to the Medical Director for review.

7. If the patient does not meet Post-Acute InterQual Criteria, the MFC Post-Acute CM will forward a referral to the Medical Director within the same day of receiving clinical information. The Medical Director will render a decision. Written notification for any adverse decisions will occur, according to Code of Maryland Regulations (COMAR) guidelines.

8. The MFC Post-Acute CM will collaborate with the Hospital CM to identify alternatives for difficult to place patients.

9. Maryland MCO members who have an anticipated length of stay greater than 90 days will require a Maryland Department of Health (MDH) form 3871 by day seventy five (75). MFC adheres to the 90 day medical necessity criteria established by the 3871. The MFC Post-Acute CM will monitor for notice of disenrollment from the MCO and follow up with MDH if this is not received in a timely manner.

B. Community Patients:
1. The Post-Acute CM will discuss alternative options of care with the patient, family and Primary Care Physician (PCP). The CM will verify identification and authority to discuss this information prior to any information being released.

2. The CM will coordinate completion of necessary paperwork for placement including the Primary Care Provider writing orders for medications, therapy, wound care, etc., MMRI

[1] For purposes of this document, ADLs consist of bathing, dressing, mobility, toileting/continence, and eating.
[2] For purposes of this document, IADLs consist of telephone use. money management, housekeeping, and medication management

screen, and assist in retrieving documentation of a recent chest x-ray, PPD, PT/OT/SLP evals or discharge summary.

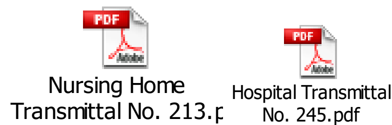
3. The CM will discuss the case with the MFC Post-Acute CM(s) to assure appropriate alternatives are presented to the patient.

4. The CM will contact the facility liaison(s) or admissions coordinator(s) to assess the patient for admission.

5. The facility liaisons will contact the MFC Post-acute Case Manager to coordinate the level of care, initial length of stay, and to receive necessary authorizations.

C. Denial Letters:
1. The Post-Acute CM will generate the Inpatient Member Liability Denial letter in the Clinical Software System and follow protocol for Member Liability inpatient denial process, as documented in the MFC policy, 110A; UM Process. Once the letter is completed, the MFC Post-Acute CM proof-reads the document. The Manager of Utilization Management (UM) or designee must also proof read the letter for NCQA/readability and compliance with standards.

2. The Administrative Assistant or designee will send the denial letter via regular mail. The following receive the letter:
   a. Patient or responsible party
   b. Facility
   c. Primary Care Physician (PCP)



Summary of Changes:	**07/20:** • Updated Regulatory References to reflect COMAR recodification. • Section A # 6 new procedures added to allow the nurse to approve continued SAC/SNF stays beyond what is allowed by InterQual up to day 90. • Section B # 2 clarified what documentation is needed to place a member from the community in a skilled facility. **07/19:** • Removal of "Maryland" from scope. • Section C #1 removed last sentence about signing the Medical Directors name to the letter. **07/18:**

	• Removed Sharon Henry from Responsible Parties. • Added COMAR: 10.09.67.12, MDH Hospital Transmittal No. 245, MDH Nursing Home Transmittal No. 213 to Regulatory References. • Clarify that MFC also uses MDH Nursing Home Transmittal No. 213 to evaluate for placement. • Removed all of the DC references in the Regulatory References. • #6 removed the text for District of Columbia contract. • #9 & #10 deleted as these were all reference to process for disenrollment for the DC Health Plan members. • Modified Effective Date to Initial Effective Dates; added Historical Revision Dates and Revision Effective Dates; and added Historical Review Dates and Review Effective Dates. **07/17:** • Added Regulatory Reference: C.6.11.8.1 request for disenrollment. • Changed Approved from Carol Attia to Theresa Bittle and updated Dr. Toye's title from Senior Medical Director to Chief Medical Officer. • Changed reference from Physician Advisor to Medical Director. • DHMH to Maryland Department of Health (MDH). • #9 clarified language for DC Health Family Members on which facilities the members can be disenrolled from who have who have stayed greater than 30 days. • Removed language about the denial letter to the member being sent via certified mail. **01/17:** • Changed 30 days to 90 days in #8 in the Inpatient section. • Changed having a completed 3871 by day twenty one (21) to day seventy five (75). **10/16:** • Updated the regulatory references. • CCMS to Clinical Software System. **10/15:** • Policy updated to include MD and DC plans. • Title updated to include placement as well as disenrollment. • Added process to notify DHCF of potential disenrollment to LTC. • Added process for notification of denials for inpatient days in a long term care facility.